Swallowing Disorder Consultation and Referral Form

Part 1: Referral to school-based swallowing team

Student:_____ Date of Birth:_____

Person Requesting Consultation:_____ Date_____

Instructions: Please check all characteristics that apply to the student.

_____ Poor upper body control
_____ Repeated respiratory infections or recurring pneumonia
_____ Poor oral motor functioning
_____ Receives nutrition through tube feeding
_____ Maintains open mouth posture
_____ Vocal cord paralysis
_____ Drooling
_____ Nasal regurgitation
_____ Cleft palate
_____ Food remains in mouth after meals (pocketing)
_____ Coughing/choking during meals
_____ Eyes watering/tearing during mealtime
_____ Unusual head/neck posturing during eating
_____ Requires special diet or diet modification (i.e. baby foods, thickener, soft food only)
_____ Hypersensitive gag reflex
_____ Reported medical of swallowing problems
_____ Weight loss/failure to thrive
_____ Refusal to eat
_____ Food and/or drink escaping from tracheostomy tube
_____ Reflux (spitting up or vomiting)
_____ Limited or unintelligible speech
_____ Mealtime takes more than 30 minutes

Additional Information or Comments:

_____

_____

_____

_____

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Part 2: Interdisciplinary Swallowing Consultation

Student:_____ Age:_____ Date of Birth:_____

Consultation Date:_____ Physician:_____

Current Diet:_____

Current positioning during meal:_____

Team members (name and titles):

_____

Rate the child's status and history during the consultation:

	Yes	No	Unknown
Current nutritional intake adequate			
Alert and oriented			
Can swallow voluntarily (on command)			
Cough, chocking, gagging during meal			
Requires increased time to eat			
"Wet" cough or voice			
Gag reflex			
Specific food avoidance behaviors: _____			
Oral apraxia			
History of frequent upper respiratory infections, pneumonia			
History of cleft lip or palate			
History of dysarthria			
History of chronic low grade fever			
History of aspiration			
History of prolonged intubation or tracheostomy			
History of neurological impairment			
History of nasal or gastric feeding			
Food allergies			
Current tracheostomy			
Current nasal or gastric tube			

Swallowing Disorder Consultation/Referral Form
Part 2 continued

General Observations
Rate student on the following scales (1 being least and 3 being most), check the appropriate description, or complete the information needed.

Behavior: Cooperative: 1 2 3
Alertness: 1 2 3

Follows directions: □ Verbal □ 1 Step □ 2 Step □ Gestures

Vision: □ No (known) Deficit □ Partial Deficit □ Severe Deficit

Trunk: □ Dystonia □ Scoliosis □ Excessive Extension

Breathing Patterns: □ Audible inhalation □ Mouth breather □ No apparent difficulty

Head control: □ Adequate □ Poor

□ Reflexive position patterns □ Jaw extension □ Grimaces/tics
□ Asymmetrical □ Contortions □ Open mouth posture
□ Increased tone □ Decreased tone
□ Receives external positioning □ Receives manual positioning
□ Excessive head/neck hyperextension

Identify any abnormal reflexes: _____

Observation of Feeding
During this assessment patient was fed _____ by _____
Positioning _____ Equipment _____

Indicate functioning by checking (+) for adequate and (-) for inadequate for each food texture.

	Liquid	Puree	Soft	Solid
Accept				
Lip Closure				
Tongue Movement				
Jaw Movement				
Swallow				
Cough				

Check any behaviors or characteristics observed during feeding:

□ Drooling □ Excessive oral secretions □ Poor oral hygiene
□ Food remnants on lips □ Bites tongue/lips □ Tongue thrust
□ Oral apraxia □ Gagging □ Cued Swallow
□ Hoarse/wet voice □ Increase clearing throat □ Coughing (>2x)(1x on milk)
□ Poor jaw control □ Absent tongue lateralization □ Fatigues easily
□ Delayed swallow

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Part 3. Physician Input Form: Swallowing

Student's Name:_____ Date of Birth:_____

Dear Dr. _____,

Your patient was observed during speech and/or occupational therapy on _____ due to feeding and swallowing concerns. The clinical indication(s) of possible aspiration included:

- □ Changes in respiration rate
- □ Coughing
- □ Oral residue
- □ Facial grimacing
- □ Gagging
- □ Refusal to eat
- □ Delay in swallowing
- □ Other: _____
- □ Reddening of the face
- □ Audible breathing
- □ Gurgled vocal quality
- □ Chronic low grade fever
- □ Pneumonia (current or history)
- □ Chronic, copious, clear secretions
- □ Questionable nutritional intake

To ensure safe and adequate nutrition and hydration during school we suggest the following:

- □ Special Diet:_____
- □ Clinical "Bedside" Swallowing Evaluation
- □ Modified Barium Swallow/Videofluoroscopy

Comments:

Sincerely:

_____	_____	_____
Speech-Language Pathologist	Occupational Therapist	Nurse
_____	_____	_____
Phone #	Phone #	Phone #

I recommend the following:

- □ Modified Barium Swallow/Videofluoroscopy
- □ Interdisciplinary Swallowing Evaluation
- □ Special Diet:_____
- □ Other:_____
- □ Impressions:_____
- □ No recommendations at this time.

Physician's Signature:_____ Date:_____